

10032

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER			
c. LENGTH OF STAY IN 1b 5 YRS.				d. STREET ADDRESS E. GREEN ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 29 1/2 N. CENTER ST				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROGER Middle HARLAN Last ANDERS				4. DATE OF DEATH Month SEPT Day 16 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 28 1879	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UPHOLSTERER				10b. KIND OF BUSINESS OR INDUSTRY CARRIAGEWORK		11. BIRTHPLACE (State or foreign country) M.D.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME THOMAS JEFFERSON ANDERS				14. MOTHER'S MAIDEN NAME SUSAN BEEMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ALBERT M. EBAUGH		Address 29 1/2 N. CENTER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS. BILATERAL 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC BRONCHITIS DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 5 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 13, 1958 , to September 16, 1958 , that I last saw the deceased alive on September 16, 1958 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Daniel J. Waller M.D.				ADDRESS (Street, city or town, state) 19 N. Church St Westminister Maryland.			
DATE SIGNED 9-16-58							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		SEPT 19, 1958		KRIDERS CEM.		WESTMINSTER MD	
23. FUNERAL DIRECTOR'S SIGNATURE D. G. BARNARD				ADDRESS WESTMINSTER, MD		24a. RECEIVED BY REGISTRAR DATE SEP 19 1958	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0088

CHARLES

WEST

ST. JAMES

ROGER

HARRAN

ANDERS

SEPT 10 1928

MARCH 28 1929

ATELECTASIS BILATERAL

CHRONIC BRONCHITIS

ARTERIO-SCLEROTIC CHRONIC VASCULAR DISEASE

CHRONIC BRONCHITIS

CHRONIC BRONCHITIS

CHRONIC BRONCHITIS

CHRONIC BRONCHITIS

CHRONIC BRONCHITIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10037

CERTIFICATE OF DEATH

Reg. Dist. No.

10026

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 m 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14, Md 3V01-4			
d. STREET ADDRESS 7231 Harford Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anthony Middle Frank Last Armetta				4. DATE OF DEATH Month 9 Day 27 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 -22 - 93	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frank Armetta				14. MOTHER'S MAIDEN NAME Rosa Guercio			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-22-5661		17. INFORMANT S.S. Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paranoid Psychosis of long standing				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-1-1958 , to 9-26-1958 , that I last saw the deceased alive on 9-26-1958 , and that death occurred at 5:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 9-27-58							
ACTUAL SIGNATURE Edmund Lusthaus M.D.							
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-1958		22c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank W. Seitz				ADDRESS 814 W 36th St Baltimore Md		24a. REC'D BY REGISTRAR DATE SEP 29 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10038

CERTIFICATE OF DEATH

Reg. Dist. No.

10027

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle MARIAN Last BISER		4. DATE OF DEATH Month 9 Day 18 Year 19 58	
5. SEX Female	6. COLOR OR RACE Caus.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1872 Aug. 3,
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Baylor		14. MOTHER'S MAIDEN NAME Mary Lotherman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Record, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with cerebral arteriosclerosis, with			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter only in Part I or Part II of item 18.) Psychotic reaction			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/5 , 19 58 , to 9/18 , 19 58 , that I last saw the deceased alive on 9/18 , 19 58 , and that death occurred at 10:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/19/58			
ACTUAL SIGNATURE Heinz H. Klaatsch		M.D. Springfield State Hospital	
PHYSICIAN'S NAME (Type) Heinz Klaatsch		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/21/58	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc		ADDRESS Hagerstown Md	
24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10028

10039

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>		c. LENGTH OF STAY IN 1b <u>1,711</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Henryton State Hospital</u>		d. STREET ADDRESS <u>4006 Addison Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Alexander Briscoe</u>		4. DATE OF DEATH Month Day Year <u>September 14 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Charles County, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Briscoe</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-48-3182</u>	
17. INFORMANT <u>Charles A. Briscoe - Patient</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Far advanced bilateral pulmonary tuberculosis</u> DUE TO (c) <u>Intestinal hemorrhage of undetermined origin</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 7, 1954</u> , to <u>September 11, 1958</u> , that I last saw the deceased alive on <u>September 11, 1958</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Henryton, Maryland</u> DATE SIGNED <u>9-14-58</u> ACTUAL SIGNATURE <u>E. M. Maculans</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. Edgar M. Maculans, Supt.</u> <u>Henryton State Hospital, Henryton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept. 20, 1958</u>		22b. DATE THEREOF <u>Woodlawn</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) (State) <u>D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Washington</u>		24a. REC'D BY REGISTRAR <u>SEP 19 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

Wahrscheinlich D.T.

Sept. 20, 1928 N. Woodbury

10040

CERTIFICATE OF DEATH

10029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore City</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN lb <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Edith</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>19 58</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-83</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u>15</u> Min. <u>00</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		12. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Joseph Brown</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. MOTHER'S MAIDEN NAME <u>Elizabeth C. D ougherty</u>		16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
17. SOCIAL SECURITY NO. <u> </u>		18. INFORMANT <u>Springfield State Hospital, Sykesville, Md.</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis, and</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>Diabetes Mellitus</u>	
23. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		24. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		26. (City or town) (County) (State) <u> </u>	
27. I certify that I attended the deceased from <u>5-9</u> , 19 <u>58</u> , to <u>9-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-19</u> , 19 <u>58</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Agustin del Campo</u> M.D. <u>Springfield State Hospital</u>		PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u> <u>Sykesville, Maryland</u>	
28. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		29. DATE THEREOF <u>9-22-1958</u>	
30. NAME OF CEMETERY OR CREMATORY <u>AYRES CHAPEL</u>		31. LOCATION (City, town, or county) (State) <u>NORRISVILLE, HARTFORD CO., Md.</u>	
32. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		33. ADDRESS <u> </u>	
34. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>		35. REGISTRAR'S SIGNATURE <u> </u>	

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10041

CERTIFICATE OF DEATH

10030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5yrs, 9mo, 15dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase 15 X-2	
3. NAME OF DECEASED (Type or print) First Helen Middle Collin Last Brunson		4. DATE OF DEATH Month September Day 24 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Chronic rheumatic heart disease DUE TO (c) Chronic brain syndrome associated with disturbance of growth, metabolism, or nutrition, senile brain disease, with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH Few days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic brain syndrome associated with disturbance of growth, metabolism, or nutrition, senile brain disease, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 491X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1954 to September 24, 1958 , that I last saw the deceased alive on September 24, 1958 , and that death occurred at 8:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Rita S. Glahn		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Rita S. Glahn, M. D.		DATE SIGNED 9/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-58	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Church		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth W. Haight Sykesville, Md		24a. REC'D BY REGISTRAR SEP 30 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of cremation		19. Signature of other disposition		20. Signature of other disposition	
21. Signature of other disposition		22. Signature of other disposition		23. Signature of other disposition		24. Signature of other disposition	
25. Signature of other disposition		26. Signature of other disposition		27. Signature of other disposition		28. Signature of other disposition	
29. Signature of other disposition		30. Signature of other disposition		31. Signature of other disposition		32. Signature of other disposition	
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97. Signature of other disposition		98. Signature of other disposition		99. Signature of other disposition		100. Signature of other disposition	

10042

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE L. BUCKEY</u>		4. DATE OF DEATH Month Day Year <u>SEPT 16 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/1863</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY HOOGE</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN SHANK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS FRANK DAVIS, WASHINGTON D.C.</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Similarity - Virus Intestinal</u> 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>waste - lack of appetite</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-1-, 1958, to 9-16-, 1958, that I last saw the deceased alive on 9-16-, 1958, and that death occurred at 8 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE <u>T. H. PEGG</u> M.D.	ADDRESS (Street, city or town, state) <u>Union Bridge MD</u>	DATE SIGNED <u>9-17-58</u>
PHYSICIAN'S NAME (Type) <u>T. H. PEGG MD</u>	<u>UNION BRIDGE MD</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>	22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Evans</u>		24a. REC'D BY REGISTRAR <u>SEP 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Duration of illness		8. Name of physician	
9. Name of informant		10. Signature of informant		11. Signature of physician		12. Signature of registrar	
13. Name of funeral home		14. Name of cemetery		15. Name of burial place		16. Name of burial place	
17. Name of burial place		18. Name of burial place		19. Name of burial place		20. Name of burial place	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10085 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10032

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 40 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 65 N. COLONIAL AVE.			d. STREET ADDRESS 65 N. COLONIAL AVE.		
3. NAME OF DECEASED (Type or print) ELMER First IV Middle CAPLE Last			4. DATE OF DEATH Month Sept. Day 6 Year 1958		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 23, 1889	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTAL CLERK, RETIRED			10b. KIND OF BUSINESS OR INDUSTRY CARROLL CO, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME RHESA N. CAPLE			14. MOTHER'S MAIDEN NAME ELLA V. GORSUCH		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. Elmer N. Caple, Westminster, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH MIN YEARS.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/6/58	
EXAMINER'S NAME (Type) JAMES T. MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 10, '58		22c. NAME OF CEMETERY OR CREMATORY SANDY MOUNT, CEM.	
22d. LOCATION (City, town, or county) (State) RURAL, WESTMINSTER, MD.		24a. REC'D BY REGISTRAR SEP 9 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myer, Jr., Westminster, Md.					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10034

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>269 E. MAIN ST.</u>				d. STREET ADDRESS <u>269 E. MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>M.</u> Last <u>GORBIN</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14, 1882</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL FRANCE</u>				14. MOTHER'S MAIDEN NAME <u>SALLY MURPHY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIAM F. GORBIN SR</u> Address <u>269 E. MAIN ST. WESTMINSTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>49</u> , to <u>9-5-</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>58</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Reese Wilkens</u>				ADDRESS (Street, city or town, state) <u>15 Kenner Westminister</u>			
PHYSICIAN'S NAME (Type) <u>DR E. REESE WILKENS</u>				DATE SIGNED <u>16/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 8, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER, MD. WESTMINSTER, MD.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David Bankard Westminister, Md</u>				24a. REC'D BY REGISTRAR <u>DATE SEP 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Funeral Home	
16. Signature of Cemetery		17. Signature of Burial Place		18. Signature of Burial Date	
19. Signature of Burial Time		20. Signature of Burial Place		21. Signature of Burial Date	
22. Signature of Burial Time		23. Signature of Burial Place		24. Signature of Burial Date	
25. Signature of Burial Time		26. Signature of Burial Place		27. Signature of Burial Date	
28. Signature of Burial Time		29. Signature of Burial Place		30. Signature of Burial Date	
31. Signature of Burial Time		32. Signature of Burial Place		33. Signature of Burial Date	
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52. Signature of Burial Time		53. Signature of Burial Place		54. Signature of Burial Date	
55. Signature of Burial Time		56. Signature of Burial Place		57. Signature of Burial Date	
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73. Signature of Burial Time		74. Signature of Burial Place		75. Signature of Burial Date	
76. Signature of Burial Time		77. Signature of Burial Place		78. Signature of Burial Date	
79. Signature of Burial Time		80. Signature of Burial Place		81. Signature of Burial Date	
82. Signature of Burial Time		83. Signature of Burial Place		84. Signature of Burial Date	
85. Signature of Burial Time		86. Signature of Burial Place		87. Signature of Burial Date	
88. Signature of Burial Time		89. Signature of Burial Place		90. Signature of Burial Date	
91. Signature of Burial Time		92. Signature of Burial Place		93. Signature of Burial Date	
94. Signature of Burial Time		95. Signature of Burial Place		96. Signature of Burial Date	
97. Signature of Burial Time		98. Signature of Burial Place		99. Signature of Burial Date	
100. Signature of Burial Time		101. Signature of Burial Place		102. Signature of Burial Date	

ORIGINAL FILED IN

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10043

CERTIFICATE OF DEATH

10034

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Adams	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		c. LENGTH OF STAY IN 1b 4 Months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Littlestown		75 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Nr. Union Mills, Westminster, Md. R.D.		d. STREET ADDRESS 409 Prince Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Luther Last Cratin		4. DATE OF DEATH Month September Day 10 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bank Employee		10b. KIND OF BUSINESS OR INDUSTRY Bank	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel W. Cratin		14. MOTHER'S MAIDEN NAME Sarah Kesselring	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-01-9332	
17. INFORMANT <i>Mrs. Harry L. Cratin</i> Mrs. Harry L. Cratin, 409 Prince St. Littlestown		Address Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO (c) 2 YEARS		INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1 , 19 58 , to 9-10 , 19 58 , that I last saw the deceased alive on 9-10 , 19 58 , and that death occurred at 8:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R.P. Potter M.D.		ADDRESS (Street, city or town, state) 12 W. King St. Littlestown, Pa.	
PHYSICIAN'S NAME (Type) L.L. POTTER M.D.		DATE SIGNED 9-11-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/58	
22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frame</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10044
CERTIFICATE OF DEATH

10035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown Rural c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Uniontown Rural d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clara Deborah Crouse		4. DATE OF DEATH Month Day Year September 13 19 58	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1869
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hamburg		14. MOTHER'S MAIDEN NAME Rebecca Warefield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Russell M. Crouse, Uniontown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Seriously DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1-1958 to 9-13-1958 , that I last saw the deceased alive on 9-12-1958 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Legg		ADDRESS (Street, city or town, state) Union Bridge	
PHYSICIAN'S NAME (Type) T. H. Legg MD		DATE SIGNED 9-15-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 16, 1958	
22c. NAME OF CEMETERY OR CREMATORY Church of God Cemetery		22d. LOCATION (City, town, or county) (State) Uniontown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son		ADDRESS Taneytown, Maryland	
24a. REC'D BY REGISTRAR SEP 16 58		24b. REGISTRAR'S SIGNATURE James S. Hume	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RALPH LEROY DOWERY</u>		4. DATE OF DEATH Month Day Year <u>SEPT 16 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ELWOOD DOWERY</u>		14. MOTHER'S MAIDEN NAME <u>MARY C. THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>ELWOOD DOWERY, UNION BRIDGE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Enteritis, Virus</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>9-13-</u> 19 <u>58</u> , to <u>9-16</u> 19 <u>58</u> , that I last saw the deceased alive on <u>9-15</u> 19 <u>58</u> , and that death occurred at <u>7:45 P.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Union Bridge</u> DATE SIGNED <u>9-17-58</u> ACTUAL SIGNATURE <u>J H Legg</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>J H LEGG MD</u> <u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEM</u>	22d. LOCATION (City, town, or county) (State) <u>FREDERICK COUNTY MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartley</u> ADDRESS <u>Union Bridge Md</u>		24a. REC'D BY REGISTRAR <u>SEP 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10046

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 10mos. 10days		3V01-44	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2312 Fleet Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Frank Last Droz		4. DATE OF DEATH Month September Day 30 , Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1903
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cross cut sawer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Blase Drozd		14. MOTHER'S MAIDEN NAME Mary Rug	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 218-01 -3446	
17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involuntional psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH 2 yrs. plus
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 20, 19 57 , to September 30, 19 58 , that I last saw the deceased alive on September 29, 19 58 , and that death occurred at 7:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 9/30/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/4/58	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery
22d. LOCATION (City, town, or county) (State) 1300 Dundalk Ave Balto, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE George G. Weber		ADDRESS 705 S. ANN ST	
24a. REC'D BY REGISTRAR 1 '58		24b. REGISTRAR'S SIGNATURE Carlton E. Howard	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
10047
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film 6233 9-18-58 et
CERTIFICATE OF DEATH

10038

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Rose Margaret Eppley				4. DATE OF DEATH Month Day Year September 11, 1958									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1879		9. AGE (In years last birthday) 79/80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Smith				14. MOTHER'S MAIDEN NAME Sara LaMotte									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield State Hospital, Sykesville, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the breast, Grade 2. 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.												INTERVAL BETWEEN ONSET AND DEATH Years.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Springfield State Hospital		(County) (State)			
21. I certify that I attended the deceased from March 7, 1955 , to September 11, 1958 , that I last saw the deceased alive on September 10, 1958 , and that death occurred at 5:01 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital, 9/11/58													
ACTUAL SIGNATURE Agustin del Campo				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/13/58		22c. NAME OF CEMETERY OR CREMATORY Mountain View		22d. LOCATION (City, town, or county) (State) Union Bridge, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				24. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

CERTIFICATE OF DEATH

10002

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

REPORTED BY

DATE OF BIRTH

PLACE OF BIRTH

AGE

SEX

TIME OF BIRTH

CAUSE OF BIRTH

MANNER OF BIRTH

REPORTED BY

DATE OF DEATH

PLACE OF DEATH

AGE

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TIME OF DEATH

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CAUSE OF DEATH

MANNER OF DEATH

REPORTED BY

DATE OF BIRTH

PLACE OF BIRTH

AGE

SEX

TIME OF BIRTH

CAUSE OF BIRTH

MANNER OF BIRTH

REPORTED BY

10039

Reg. Dist. No.

10048

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 mos 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Edward Farren		4. DATE OF DEATH Month Sept. Day 20 Year 1958	
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1981
9. AGE (In years last birthday) 77 7/8 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) watchman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Edward Farren		14. MOTHER'S MAIDEN NAME Charlot Mittchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-14-5654	
17. INFORMANT Annie Farren, as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with senile brain disease with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 22, 1958 , to Sept. 20, 1958 , that I last saw the deceased alive on Sept. 19, 1958 , and that death occurred at 9:00 AM , from the causes and on the date stated above Walter Knopp ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital, Sept. 20, 1958 ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) Walter Knopp, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 24, 1958	
22c. NAME OF CEMETERY OR CREMATORY Schwartz		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St.		24a. REC'D BY REGISTRAR SEP 24 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10049

CERTIFICATE OF DEATH

10040

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2y7m24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Union Bridge, Md	
3. NAME OF DECEASED (Type or print) First Alcinda Middle Adeline Last Fawcett		4. DATE OF DEATH Month 9 Day 19 Year 1958	
5. SEX Fem.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 - 17 - 78
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ridgely		14. MOTHER'S MAIDEN NAME Alcinda E. Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS. assoc. with cerebral arteriosclerosis, with psych. reaction		INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-25- 1956 , to 9-19- 1958 , that I last saw the deceased alive on 9-19- 1958 , and that death occurred at 5 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital 9-20-58 PHYSICIAN'S NAME (Type) Edmund Lusthaus Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-22-1958	
22c. NAME OF CEMETERY OR CREMATORY Providence		22d. LOCATION (City, town, or county) (State) Glenelg, Howard Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE SEP 23 '58		24b. REGISTRAR'S SIGNATURE William S. H. H.	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAVOLI		2. SEX Male		3. AGE 20	
4. PLACE OF BIRTH Baltimore, Md.		5. DATE OF BIRTH 1910		6. DATE OF DEATH 1930	
7. PLACE OF DEATH Baltimore, Md.		8. CAUSE OF DEATH Tuberculosis		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN J. H. Jones		11. SIGNATURE OF REGISTRAR J. H. Jones		12. SIGNATURE OF WITNESSES J. H. Jones	
13. NAME OF FUNERAL HOME J. H. Jones		14. NAME OF BURIAL PLACE J. H. Jones		15. NAME OF CEMETERY J. H. Jones	
16. NAME OF NEXT OF KIN J. H. Jones		17. NAME OF RELIGIOUS SOCIETY J. H. Jones		18. NAME OF CHURCH J. H. Jones	
19. NAME OF MINISTER J. H. Jones		20. NAME OF DEACON J. H. Jones		21. NAME OF SUNDAY SCHOOL J. H. Jones	
22. NAME OF YOUTH LEAGUE J. H. Jones		23. NAME OF WOMAN'S SOCIETY J. H. Jones		24. NAME OF GUILD J. H. Jones	
25. NAME OF LODGE J. H. Jones		26. NAME OF ORDER J. H. Jones		27. NAME OF ASSOCIATION J. H. Jones	
28. NAME OF CLUB J. H. Jones		29. NAME OF SOCIETY J. H. Jones		30. NAME OF ORGANIZATION J. H. Jones	
31. NAME OF COMMITTEE J. H. Jones		32. NAME OF BOARD J. H. Jones		33. NAME OF COUNCIL J. H. Jones	
34. NAME OF DISTRICT J. H. Jones		35. NAME OF TERRITORY J. H. Jones		36. NAME OF DIVISION J. H. Jones	
37. NAME OF SECTION J. H. Jones		38. NAME OF BRANCH J. H. Jones		39. NAME OF CHAPTER J. H. Jones	
40. NAME OF ORDER J. H. Jones		41. NAME OF SOCIETY J. H. Jones		42. NAME OF ASSOCIATION J. H. Jones	
43. NAME OF CLUB J. H. Jones		44. NAME OF SOCIETY J. H. Jones		45. NAME OF ORGANIZATION J. H. Jones	
46. NAME OF COMMITTEE J. H. Jones		47. NAME OF BOARD J. H. Jones		48. NAME OF COUNCIL J. H. Jones	
49. NAME OF DISTRICT J. H. Jones		50. NAME OF TERRITORY J. H. Jones		51. NAME OF DIVISION J. H. Jones	
52. NAME OF SECTION J. H. Jones		53. NAME OF BRANCH J. H. Jones		54. NAME OF CHAPTER J. H. Jones	
55. NAME OF ORDER J. H. Jones		56. NAME OF SOCIETY J. H. Jones		57. NAME OF ASSOCIATION J. H. Jones	
58. NAME OF CLUB J. H. Jones		59. NAME OF SOCIETY J. H. Jones		60. NAME OF ORGANIZATION J. H. Jones	
61. NAME OF COMMITTEE J. H. Jones		62. NAME OF BOARD J. H. Jones		63. NAME OF COUNCIL J. H. Jones	
64. NAME OF DISTRICT J. H. Jones		65. NAME OF TERRITORY J. H. Jones		66. NAME OF DIVISION J. H. Jones	
67. NAME OF SECTION J. H. Jones		68. NAME OF BRANCH J. H. Jones		69. NAME OF CHAPTER J. H. Jones	
70. NAME OF ORDER J. H. Jones		71. NAME OF SOCIETY J. H. Jones		72. NAME OF ASSOCIATION J. H. Jones	
73. NAME OF CLUB J. H. Jones		74. NAME OF SOCIETY J. H. Jones		75. NAME OF ORGANIZATION J. H. Jones	
76. NAME OF COMMITTEE J. H. Jones		77. NAME OF BOARD J. H. Jones		78. NAME OF COUNCIL J. H. Jones	
79. NAME OF DISTRICT J. H. Jones		80. NAME OF TERRITORY J. H. Jones		81. NAME OF DIVISION J. H. Jones	
82. NAME OF SECTION J. H. Jones		83. NAME OF BRANCH J. H. Jones		84. NAME OF CHAPTER J. H. Jones	
85. NAME OF ORDER J. H. Jones		86. NAME OF SOCIETY J. H. Jones		87. NAME OF ASSOCIATION J. H. Jones	
88. NAME OF CLUB J. H. Jones		89. NAME OF SOCIETY J. H. Jones		90. NAME OF ORGANIZATION J. H. Jones	
91. NAME OF COMMITTEE J. H. Jones		92. NAME OF BOARD J. H. Jones		93. NAME OF COUNCIL J. H. Jones	
94. NAME OF DISTRICT J. H. Jones		95. NAME OF TERRITORY J. H. Jones		96. NAME OF DIVISION J. H. Jones	
97. NAME OF SECTION J. H. Jones		98. NAME OF BRANCH J. H. Jones		99. NAME OF CHAPTER J. H. Jones	
100. NAME OF ORDER J. H. Jones		101. NAME OF SOCIETY J. H. Jones		102. NAME OF ASSOCIATION J. H. Jones	

10050

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 mo. 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 957 Rosedale Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LAVINIA (Luvina) Marshall Green				4. DATE OF DEATH Month September Day 8 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1870	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 03 Days X-2		IF UNDER 24 HRS. Hours 03 Min. 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME (John) Marshall				14. MOTHER'S MAIDEN NAME (Unknown) Lavinia Preston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Senile with psychosis.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11, 19 58 to September 8, 19 58 that I last saw the deceased alive on September 7, 19 58 , and that death occurred at 6:00 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/8/58			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-11-58		22c. NAME OF CEMETERY OR CREMATORY Morland Park		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 1305 Harford Rd		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

10820

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John A. Smith		Male		45		Jan 15, 1925		Jan 20, 1970		Home		Heart Disease		Natural		J. H. Jones		M. B. Brown	
Residence		Occupation		Education		Marital Status		Previous Illnesses		Last Illness		Time of Death		Time of Burial		Burial Place		Remarks	
123 Main St.		Teacher		High School		Married		Hypertension		Stroke		10:00 AM		10:30 AM		St. Mary's			
City		County		State		Country		Hospital		Physician		Nurse		Burial		Cremation			
Baltimore		Anne Arundel		Maryland		USA		St. Mary's		J. H. Jones		M. B. Brown		Buried		Cremated			
Age at Death		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Remarks					
45		Jan 20, 1970		Home		Heart Disease		Natural		J. H. Jones		M. B. Brown							
Date of Birth		Sex		Age		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Remarks	
Jan 15, 1925		Male		45		Jan 20, 1970		Home		Heart Disease		Natural		J. H. Jones		M. B. Brown			
Residence		Occupation		Education		Marital Status		Previous Illnesses		Last Illness		Time of Death		Time of Burial		Burial Place		Remarks	
123 Main St.		Teacher		High School		Married		Hypertension		Stroke		10:00 AM		10:30 AM		St. Mary's			
City		County		State		Country		Hospital		Physician		Nurse		Burial		Cremation			
Baltimore		Anne Arundel		Maryland		USA		St. Mary's		J. H. Jones		M. B. Brown		Buried		Cremated			
Age at Death		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Remarks					
45		Jan 20, 1970		Home		Heart Disease		Natural		J. H. Jones		M. B. Brown							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10042

10051

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE AVE</u>		d. STREET ADDRESS <u>MAPLE AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELLEN</u> Last <u>HAINES</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 8 - 1911</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u>15</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>OLIVER HAINES</u>		14. MOTHER'S MAIDEN NAME <u>BLANCHE SELBY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-10-9228</u>	
17. INFORMANT <u>OLIVER HAINES</u>		Address <u>NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis -</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(Breast Original site.)</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>9/15/58</u> , that I last saw the deceased alive on <u>9/15/58</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Robertson</u>		M.D. <u>New Windsor, Md.</u> DATE SIGNED <u>9/15/58</u>	
PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>		<u>NEW WINDSOR MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN</u>		22d. LOCATION (City, town, or county) (State) <u>NEW WINDSOR MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D D Hartley & Sons</u>		ADDRESS <u>New Windsor Md</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10043

10052

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 1224.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 724 Girard Street	
3. NAME OF DECEASED (Type or print) First Earl Middle M. Last Hawkins		4. DATE OF DEATH Month September Day 18 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-1902
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Havre de Grace, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George O. Hawkins		14. MOTHER'S MAIDEN NAME Mattie Webster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 207-07-6819	
17. INFORMANT Earl M. Hawkins-Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced bilateral pulmonary tuberculosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 1958 , to September 18, 1958 , that I last saw the deceased alive on September 18, 1958 , and that death occurred at 1:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 9-18-58 ACTUAL SIGNATURE E. M. Maculans M.D. PHYSICIAN'S NAME (Type) Dr. Edgar M. Maculans, Supt. Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-1958	
22c. NAME OF CEMETERY OR CREMATORY Shanty Hill Cemetery		22d. LOCATION (City, town, or county) (State) Harford County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Bullock - Havre de Grace		24a. REC'D BY REGISTRAR DATE SEP 22 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10053
CERTIFICATE OF DEATH

10044

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 13yrs. 9mos. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2914 Inglewood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Theresa Mary Vickers HILES				4. DATE OF DEATH Month Day Year September 21, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1909	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Vickers				14. MOTHER'S MAIDEN NAME Minnie Puls			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis lesser omentum. 576X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sub-diaphragmatic abscess. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with convulsive disorder, epileptic deterioration.							INTERVAL BETWEEN ONSET AND DEATH 2 wks. 2 wks.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1954 to September 21, 1958 , that I last saw the deceased alive on September 21, 1958 , and that death occurred at 10:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 9/22/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 25, 1958		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe Street				24a. REC'D BY REGISTRAR SEP 24 '58		24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10054

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shelburne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5504 Lincoln St.</u>	
c. LENGTH OF STAY IN <u>3 Months</u>		d. STREET ADDRESS <u>Bethesda 14, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pullen Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u> First Middle Last <u>HIPKINS</u>		4. DATE OF DEATH <u>Sept. 12</u> Month Day Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob Ruble</u>		14. MOTHER'S MAIDEN NAME <u>Paulina Nagle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Ernest D. Thompson</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, Cardiac failure,</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bronchial pneumonia,</u> DUE TO (c) <u>12 Sept 58</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Aug 58</u> <u>10</u> <u>12 Sept 58</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 1958, to <u>Sept</u> , 1958, that I lost saw the deceased alive on <u>12 Sept</u> , 1958, and that death occurred at <u>6:15 P M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Alexandria, Md.</u> DATE SIGNED <u>12 Sept 58</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYLVESTERVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>9-13-58</u>	<u>J. W. Lee</u>	<u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Hydenville, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 16 '58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH AND DEATH REGISTRATION
CERTIFICATE OF DEATH

ALVIN BROWN

1900-1901

1902-1903

1904-1905

1906-1907

1908-1909

1910-1911

1912-1913

1914-1915

1916-1917

1918-1919

1920-1921

1922-1923

1924-1925

1926-1927

1928-1929

1930-1931

1932-1933

1934-1935

1936-1937

1938-1939

CERTIFICATE OF DEATH

Reg. Dist. No.

10046

10055

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Route #2	
3. NAME OF DECEASED (Type or print) First Jesse Middle Albert Last Horton		4. DATE OF DEATH Month September Day 29 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Asbury Horton		14. MOTHER'S MAIDEN NAME Polly Jenkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to arteriosclerosis and senility.			INTERVAL BETWEEN ONSET AND DEATH Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 22, 19 58 , to September 29, 19 58 , that I last saw the deceased alive on September 29, 19 58 , and that death occurred at 10:00M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/29/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-1-1958	22c. NAME OF CEMETERY OR CREMATORY Ebenezer	22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR DATE OCT 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1915		New York City	
Residence		Occupation		Cause of Death		Date of Death		Place of Death	
123 Main St, Boston		Teacher		Heart Disease		Jan 20 1960		Boston, Mass	
Physician		Hospital		Burial or Disposition		Date of Burial		Place of Burial	
Dr. Smith		St. Mary's		Buried		Jan 22 1960		St. Mary's Church	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Director	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10056

CERTIFICATE OF DEATH

10047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3yrs. 7mos. 23days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Route #2	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Mathilda Richenour IFERT		4. DATE OF DEATH Month Day Year September 30, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1873
9. AGE (In years birth day) 85		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cornelius Richenour		14. MOTHER'S MAIDEN NAME Anna**— Amanda C. Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/7/1955 , to September 30, 1958 , that I last saw the deceased alive on September 30, 1958 , and that death occurred at 7:39P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield Hospital	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		DATE SIGNED 10/1/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 3, 1958	
22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John L. Moleworth		24a. REC'D BY REGISTRAR DATE OCT 3 '58	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Cynthia L. Hanks	

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

ESSE, ES, etc.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10057

CERTIFICATE OF DEATH

Reg. Dist. No.

10048

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 16 220 N. Bond Street	
3. NAME OF DECEASED (Type or print) First Middle Last George Jackson		4. DATE OF DEATH Month Day Year September 5 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March ? 1908
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.	
11. BIRTHPLACE (State or foreign country) Camden, N. Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Dehnis Jackson		14. MOTHER'S MAIDEN NAME Alice Jackson ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. 217-05-3164	
17. INFORMANT George Jackson - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden cardiac death DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) Far advanced bilateral pulmonary tuberculosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 18 , 19 57 , to Sept. 5 , 19 58 , that I last saw the deceased alive on Sept. 5 , 19 58 , and that death occurred at 7:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED ACTUAL SIGNATURE E. M. Maculans M.D.			
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles B. Lewis		24a. REC'D BY REGISTRAR 8 '58	
ADDRESS 1639 N. Bond Street		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		APR 4 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		JAMES EARL RAY		JAMES EARL RAY	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		OCCUPATION		RELIGION		MARRIED		SINGLE		WIDOW		DIVORCED		MARRIED		DIVORCED	
JAMES EARL RAY		JAMES EARL RAY		HIGH SCHOOL		LABORER		METHODIST		YES		NO		NO		NO		YES		NO	
DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN	
JAN 15 1950		MEMPHIS, TENNESSEE		APR 4 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		OCCUPATION		RELIGION		MARRIED		SINGLE		WIDOW		DIVORCED		MARRIED		DIVORCED	
JAMES EARL RAY		JAMES EARL RAY		HIGH SCHOOL		LABORER		METHODIST		YES		NO		NO		NO		YES		NO	
DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN	
JAN 15 1950		MEMPHIS, TENNESSEE		APR 4 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10058
CERTIFICATE OF DEATH

10049

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 yrs. 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2612 Huntingdon Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Vernon Last KELLER		4. DATE OF DEATH Month September Day 1, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1875
9. AGE (In years and birth day) 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Bernard Keller		14. MOTHER'S MAIDEN NAME Adeline - Barker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of myocardium due to coronary occlusion. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Instant			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1954 , to September 1, 1958 , that I last saw the deceased alive on August 31, 1958 , and that death occurred at 6:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 9/1/58			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-3-1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong		ADDRESS 3207 W. North Ave	
24a. REC'D BY REGISTRAR DATE SEP 2 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

CERTIFICATE OF DEATH

1903

1. Name of deceased		2. Sex		3. Age		4. Date of death	
John Doe		Male		35		Jan 15, 1903	
5. Cause of death		6. Place of death		7. Name of physician		8. Name of attending physician	
Heart Disease		Home		Dr. J. B. Smith		Dr. J. B. Smith	
9. Name of informant		10. Name of informant		11. Name of informant		12. Name of informant	
John Doe		John Doe		John Doe		John Doe	
13. Name of informant		14. Name of informant		15. Name of informant		16. Name of informant	
John Doe		John Doe		John Doe		John Doe	
17. Name of informant		18. Name of informant		19. Name of informant		20. Name of informant	
John Doe		John Doe		John Doe		John Doe	
21. Name of informant		22. Name of informant		23. Name of informant		24. Name of informant	
John Doe		John Doe		John Doe		John Doe	
25. Name of informant		26. Name of informant		27. Name of informant		28. Name of informant	
John Doe		John Doe		John Doe		John Doe	
29. Name of informant		30. Name of informant		31. Name of informant		32. Name of informant	
John Doe		John Doe		John Doe		John Doe	
33. Name of informant		34. Name of informant		35. Name of informant		36. Name of informant	
John Doe		John Doe		John Doe		John Doe	
37. Name of informant		38. Name of informant		39. Name of informant		40. Name of informant	
John Doe		John Doe		John Doe		John Doe	
41. Name of informant		42. Name of informant		43. Name of informant		44. Name of informant	
John Doe		John Doe		John Doe		John Doe	
45. Name of informant		46. Name of informant		47. Name of informant		48. Name of informant	
John Doe		John Doe		John Doe		John Doe	
49. Name of informant		50. Name of informant		51. Name of informant		52. Name of informant	
John Doe		John Doe		John Doe		John Doe	
53. Name of informant		54. Name of informant		55. Name of informant		56. Name of informant	
John Doe		John Doe		John Doe		John Doe	
57. Name of informant		58. Name of informant		59. Name of informant		60. Name of informant	
John Doe		John Doe		John Doe		John Doe	
61. Name of informant		62. Name of informant		63. Name of informant		64. Name of informant	
John Doe		John Doe		John Doe		John Doe	
65. Name of informant		66. Name of informant		67. Name of informant		68. Name of informant	
John Doe		John Doe		John Doe		John Doe	
69. Name of informant		70. Name of informant		71. Name of informant		72. Name of informant	
John Doe		John Doe		John Doe		John Doe	
73. Name of informant		74. Name of informant		75. Name of informant		76. Name of informant	
John Doe		John Doe		John Doe		John Doe	
77. Name of informant		78. Name of informant		79. Name of informant		80. Name of informant	
John Doe		John Doe		John Doe		John Doe	
81. Name of informant		82. Name of informant		83. Name of informant		84. Name of informant	
John Doe		John Doe		John Doe		John Doe	
85. Name of informant		86. Name of informant		87. Name of informant		88. Name of informant	
John Doe		John Doe		John Doe		John Doe	
89. Name of informant		90. Name of informant		91. Name of informant		92. Name of informant	
John Doe		John Doe		John Doe		John Doe	
93. Name of informant		94. Name of informant		95. Name of informant		96. Name of informant	
John Doe		John Doe		John Doe		John Doe	
97. Name of informant		98. Name of informant		99. Name of informant		100. Name of informant	
John Doe		John Doe		John Doe		John Doe	

RECEIVED
JAN 15 1903
BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10050

10059

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 15 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		d. STREET ADDRESS 1303 Crofton Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charlotte Middle Schloer Last Maiberg		4. DATE OF DEATH Month 9 Day 27 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-75
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Schloer		14. MOTHER'S MAIDEN NAME Matilda Koerner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-03-1959A	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia. 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease, with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-12-1958 to 9-27-1958 , that I last saw the deceased alive on 9-27-58 , and that death occurred at 10.18 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Agustin del Campo M.D.		Springfield State Hospital, Sykesville 9-28-58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-5-58		22b. DATE THEREOF Baltimore	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Luck		ADDRESS 1305 Harford	
24a. REC'D BY REGISTRAR DATE OCT 6 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11. 11. 1950

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Top Info

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

1000000

1997) and the fact that the *in vitro* and *in vivo* results are in good agreement.

Figure 1. The effect of the concentration of the *Agrobacterium* suspension on the transformation efficiency of *Agrobacterium* strains.

• **Chlorine** is used in the production of plastics, solvents, and disinfectants.

10060

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. LENGTH OF STAY IN 1b <u>6 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROSE-TRACEY-MAYS</u>				4. DATE OF DEATH <u>Sept 6 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16 - 1870</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm H Tracey</u>				14. MOTHER'S MAIDEN NAME <u>Amy M Monford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Frank Mayo - Upperco, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Concurrent Heart Failure</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 13 1958</u> , to <u>Sept 6 1958</u> , that I last saw the deceased alive on <u>Sept 5 1958</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W H Foard</u>				ADDRESS (Street, city or town, state) <u>MANCHESTER, MD.</u> DATE SIGNED <u>9/6/58</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Foard, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Epton</u> ADDRESS <u>Hampstead Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

CERTIFICATE OF DEATH

10060

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

10061

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1920</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1945</i></p>	
<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>11. MANNER OF DEATH <i>Natural</i></p>		<p>12. DATE OF DEATH <i>Dec 10 1965</i></p>	
<p>13. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>15. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>16. SIGNATURE OF REGISTRAR <i>John Doe</i></p>	

CERTIFICATE OF DEATH

Reg. Dist. No.

10061

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 700 N. Baltimore St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle C. Last Mooney		4. DATE OF DEATH Month September Day 1 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH - 1887
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Mooney		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced, active. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to alcoholism 322.2		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____

21. I certify that I attended the deceased from August 29, 1958 , to September 1, 1958 , that I last saw the deceased alive on September 1, 1958 , and that death occurred at 8:50 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Edmund Lusthaus	DATE SIGNED 9/1/58
ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland	

22a. BURIAL, CREMATION, REMOVAL (Specify) 9-4-58	22b. DATE THEREOF 9-4-58	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Newell		24a. REC'D BY REGISTRAR SEP 8 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. JONES		Male		35		Jan 15, 1935		Baltimore, Md.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 Main St.		Teacher		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		PLACE OF DEATH	
Jan 20, 1970		10:00 AM		10:00		00		Home	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
Jan 20, 1970		Jan 20, 1970		Jan 20, 1970		Jan 20, 1970		Jan 20, 1970	

10-1000-1-70

10062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> 1011.2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>32 Jefferson St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Morgan</u> Middle <u>Morgan</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-81</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Robertson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital File</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-12</u> , 19 <u>58</u> , to <u>9-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-26</u> , 19 <u>58</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Yasuo Takahashi</u> M.D.		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>YASUO TAKAHASHI</u>		DATE SIGNED <u>Springfield State Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-29-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Harpers Ferry, West Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Lee Felt</u> ADDRESS <u>Brunswick, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 30 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your health, or at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG RURAL</u>		c. LENGTH OF STAY IN 1b <u>3 HOURS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>WOODS BORO</u> <u>10X-2</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>HARRISON</u> Middle <u>MORT</u> Last <u>Jr.</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 6--1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BY DAY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLASTERER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM H MORT</u>		14. MOTHER'S MAIDEN NAME <u>RUTH CUTSHALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-07-6075</u>	
17. INFORMANT <u>NETTIE MORT</u>		Address <u>KEYMAR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/17/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HAUCHS</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Powell Hartzler Woodboro Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

THE STATE
HEALTH DEPT.



RECEIVED
JAN 10 1918
HEALTH DEPT.
Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10
JAN 10 1918
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: _____
AGE: _____ SEX: _____
DATE OF DEATH: _____
PLACE OF DEATH: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF EXAMINER: _____
OFFICE OF EXAMINER: _____

1. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

2. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

3. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

4. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

5. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

6. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

7. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

8. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

9. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

10. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10064

CERTIFICATE OF DEATH

10055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington 15 x - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 9520 W. Stanhope Rd.	
3. NAME OF DECEASED (Type or print) First James Middle Albert Last NOYES		4. DATE OF DEATH Month September Day 26 , Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75	IF UNDER 24 HRS. Days 75 Hours 75 Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Noyes		14. MOTHER'S MAIDEN NAME Mary Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-07-0476	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 521X Multiple lung abscesses DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Rheumatic heart disease.			INTERVAL BETWEEN ONSET AND DEATH 1 - 2 wks.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 4, 1958 , to September 26, 1958 , that I last saw the deceased alive on September 25, 1958 , and that death occurred at 3:10A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		DATE SIGNED 9/26/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
9/29/58	9/29/58	FORT LINCOLN	Prince Geo. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sawlen Saw		ADDRESS Wash. D.C.	
24a. REC'D BY REGISTRAR SEP 29 1958		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1900		Home	
Cause of Death		Disease		Symptoms		Time of Death		Physician	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		10:00 AM		Dr. J. Smith	
Occupation		Education		Marital Status		Religion		Burial Place	
Teacher		High School		Married		Catholic		St. Mary's Church	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10065

CERTIFICATE OF DEATH

Reg. Dist. No.

10056

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3001-4 ✓			
f. STREET ADDRESS Little Sisters of the Poor 1200 Valley St. Baltimore 2, Md.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELSIE Middle VIRGINIA Last (SMITH)				DATE OF DEATH Month September Day 26 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-28-74	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min.		IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ELI SMITH				14. MOTHER'S MAIDEN NAME MARY HALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart disease DUE TO (c) Generalised Arterio sclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-15 , 19 56 , to 9-26 , 19 58 , that I last saw the deceased alive on 9-26 , 19 58 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Rita S. Glahn				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9-26-58			
PHYSICIAN'S NAME (Type) Rita S. Glahn, M. D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-1958		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong ADDRESS 3007 W. North Ave				24a. REC'D BY REGISTRAR SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Evans	

10066

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 yrs. 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lulu Middle Creighton Last Phillips		4. DATE OF DEATH Month September Day 1 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Creighton		14. MOTHER'S MAIDEN NAME Sue Creighton SUE M. TRAVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 19 54 , to September 1, 19 58 , that I last saw the deceased alive on September 1, 19 58 , and that death occurred at 9:50A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 9/1/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/3/58	
22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR SEP 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24, Md.	
c. LENGTH OF STAY IN 1b 1 year 14 days		d. STREET ADDRESS 27 N. Port Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elmer Middle Lewis Last Rehmert		4. DATE OF DEATH Month 9 Day 26 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR: Months 58 Days 58 Hours 58 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Rehmert		14. MOTHER'S MAIDEN NAME Elizabeth Bean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 18-20, 43-44	
17. INFORMANT Hospital Records (Springfield & V.A.)		Address unkn	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, far Advanced, DUE TO (b) 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) --- DUE TO (b) --- DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with chro nic alcoholism & mental deficiency			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-12- , 19 57 , to 9-26- , 19 58 , that I last saw the deceased alive on 9-26- , 19 58 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		DATE SIGNED 9-27-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/30/58	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran-3000 E. Baltimore St.		24a. REC'D BY REGISTRAR SEP 29 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1907

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

TIME

PLACE

CAUSE

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELATIONSHIP TO DECEASED

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

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10059

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Springfield State Hosp.</u> <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN <u>154. 26 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State</u>		d. STREET ADDRESS <u>Emmitsburg</u> 10 X - 2	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>J. NORRIS</u> Last <u>Rowe</u>		4. DATE OF DEATH Month <u>9</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	IF UNDER 24 HRS. Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frederick Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Norris</u>		14. MOTHER'S MAIDEN NAME <u>E</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>S.S.H.</u> Address: <u>Sykesville Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis of brain</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. anox. with cerebral arteriosclerosis with prethrombosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-25</u> , 19 <u>49</u> , to <u>9-20-58</u> , 19 <u>58</u> that I last saw the deceased alive on <u>9-19-58</u> , 19 <u>58</u> , and that death occurred at <u>3:20</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ilse Kann</u>		DATE SIGNED <u>4 Grand View - 4 Sykesville Ind</u>	
PHYSICIAN'S NAME (Type) <u>Ilse Kann</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Art. Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.H. Kane</u>		ADDRESS <u>2901 14th NW</u>	
24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

VS AIS (4)
15M 10/57

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10070

CERTIFICATE OF DEATH

Reg. Dist. No.

10061

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>				d. STREET ADDRESS <u>JARRETTSVILLE 12X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Kurtz</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 26, 1865</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MARTIN Kurtz</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN Mead</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>SARA Smith, Jarrettsville MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerotic Cardio-Renal Vascular Disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Sept 5</u> , 19 <u>57</u> , to <u>Sept 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 29</u> , 19 <u>58</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Maryland</u>			
DATE SIGNED <u>9/2/58</u>							
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				HAMPSTEAD Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hornsville</u>		22d. LOCATION (City, town, or county) (State) <u>Hornsville Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick S. Smith</u>				ADDRESS <u>Jarrettsville</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH—BALTIMORE 10

10071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN - W - SPAHR</u> First Middle Last		4. DATE OF DEATH <u>Sept 25</u> 19 <u>58</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 28 - 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Flour Miller</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Spahr</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Raffenberger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>204-01-3528</u>	
17. INFORMANT <u>Harold Spahr</u> Address <u>Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio-sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure, Arthritis, Fibrosis of right lung</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>48</u> , to <u>September 25</u> 19 <u>58</u> , that I last saw the deceased alive on <u>September 24</u> 19 <u>58</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u> DATE SIGNED <u>9/25/58</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		<u>Hampstead, Md.</u> <u>9/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-27-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Lipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

10072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Winfield		c. LENGTH OF STAY IN 1b MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminister	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oak Tree Road nr. Bear Branch Road			d. STREET ADDRESS 93 Pennsylvania Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LORRAINE BERWAGER STEM			4. DATE OF DEATH Month September Day 7 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13 1930		9. AGE (In years last birthday) 28 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN & MECHANIC - AUTO.		10b. KIND OF BUSINESS OR INDUSTRY M.D.		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME LORRAINE W. STEM			14. MOTHER'S MAIDEN NAME GRACE BERWAGER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-26-7220		17. INFORMANT LORRAINE W. STEM Address N. PLEASANT VALLEY MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of neck and head 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted gunshot wound			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) nr. Winfield Carroll Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/8/58	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 10 '58	22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY SILVER RUN MD.		22d. LOCATION (City, town, or county) (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE David G. Bankard		ADDRESS Westminister, Md.		24a. REC'D BY REGISTRAR DATE SEP 11 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death at a hospital or attending physician.

After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be placed in the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the burial, cremation, or removal, and in any event within 72 hours after death.

10073

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DOROTHEA W. STEVENSON</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>6</u> Year <u>19 58</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/22/1898</u>	
9. AGE (In years "last birthday") <u>80</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HARRY SMITH</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE SHUEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>EDNA SMITH, NEW WINDSOR, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/1/58</u> , 19____, to <u>9/6/58</u> , 19____, that I last saw the deceased alive on <u>9/5/58</u> , 19____, and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u>				ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> DATE SIGNED <u>9/6/58</u>			
PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>				NEW WINDSOR MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. D. Hartley & Sons</u>				ADDRESS <u>New Windsor Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

CERTIFICATE OF DEATH

10073

DATE

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

OCCUPATION

EDUCATION

Marital Status

Previous Illnesses

Signature of Physician

Signature of Registrar

Signature of Informant

Signature of Coroner

Signature of Burial Officer

Signature of Minister

Signature of Undertaker

Signature of Cemetery

Signature of Funeral Home

Signature of Mortician

Signature of Embalmer

Signature of Crematorium

Signature of Interment

Signature of Burial

Signature of Disposition

Signature of Final Rest

Signature of Eternal Peace

Signature of Lasting Memory

Signature of Forever Home

Signature of Rest in Peace

Signature of Amen

Signature of Goodbye

Signature of Adieu

Signature of Farewell

Signature of Goodnight

10035

CERTIFICATE OF DEATH

Reg. Dist. No.

10065

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>6 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>88 W. MAIN ST.</u> At home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>AGNES HELENA SUTTEY</u>				4. DATE OF DEATH <u>SEPT. 17 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 17 1921</u> 37 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE MUMMAUGH</u>				14. MOTHER'S MAIDEN NAME <u>AGNES WATSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>VERONIE SEALOVER</u> Address <u>PASADENA MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>480X</u> DUE TO <u>"Flu"</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>"Flu"</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>32 day</u> <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 14 1958</u> , to <u>Sept 17 1958</u> , that I last saw the deceased alive on <u>Sept 17 - 1958</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.C. Jermuth</u>		M.D. <u>103 E. Main Westminster Md.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Wm Carl Sennett MD</u>		M.D. <u>Westminster Md.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM. WESTMINSTER MD</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David C. Edwards Westminster Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Place of death		10. Signature of physician		11. Signature of registrar	
John Doe		Male		45		Jan 1, 1900		Baltimore, Md.		Baltimore, Md.		Heart disease		Jan 15, 1945		Baltimore, Md.		J. Smith		A. Jones	
12. Name of informant		13. Relationship		14. Address		15. City		16. State		17. Zip		18. Signature of informant		19. Date of completion		20. Registrar's stamp		21. Registrar's signature		22. Registrar's date	
Jane Doe		Wife		123 Main St.		Baltimore		Md.		21201		J. Doe		Jan 16, 1945		[Stamp]		A. Jones		Jan 16, 1945	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10074

CERTIFICATE OF DEATH

10066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 10 y 4 m 7 d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 429 N. Rose St., Baltimore 24,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle (Brooks) Last Mamie Stricker				4. DATE OF DEATH Month September Day 6th Year 1958					
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-1-21			
9. AGE (In years and birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY dependent		11. BIRTHPLACE (State or foreign country) West Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME William Brooks				14. MOTHER'S MAIDEN NAME Viola Kroll					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT S.S. Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Passive congestion of heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Rheumatic heart disease, inactive DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychosis with convulsive disorder, epileptic deterioration								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from 10-20- , 19 54 , to 9-5- , 19 58 , that I last saw the deceased olive on 9-5- , 19 58 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE Edmund Lusthaus M.D.				Springfield State Hospital 9-6-58					
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.				Sykesville, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/58		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.				24a. REC'D BY REGISTRAR DATE SEP 9 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

15

1

2

SP

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1900		Baltimore, Md.	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		Jan 20 1945		Home	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Teacher		High School		Married		Catholic		[Signature]	
Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT OF 1906, AS AMENDED BY THE ACT OF 1920, 1922, 1924, 1926, 1928, 1930, 1932, 1934, 1936, 1938, 1940, 1942, 1944, 1946, 1948, 1950, 1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966, 1968, 1970, 1972, 1974, 1976, 1978, 1980, 1982, 1984, 1986, 1988, 1990, 1992, 1994, 1996, 1998, 2000, 2002, 2004, 2006, 2008, 2010, 2012, 2014, 2016, 2018, 2020.

10036

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>69 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>37 LIBERTY</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADA A. VAN-FOSSEN</u>				4. DATE OF DEATH Month Day Year <u>SEPT 26 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25, 1889</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>J. WESLEY KING</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE MILLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-0919</u>		17. INFORMANT <u>DUDLEY K. VAN FOSSEN</u>		Address <u>37 LIBERTY WESTMINSTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pernicious Anemia & Arthritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Several for 5 yrs.</u> <u>about 3 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>58</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 19</u> , 19 <u>55</u> , to <u>Sept. 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 26</u> , 19 <u>58</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. L. Billingslea</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Westminster, Md. 9-27-58</u>			
PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 30, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FEISTERS CEM. RAY WESTMINSTER MD.</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bankard</u>				ADDRESS <u>Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Quibus & Hous</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED WILLIAM WEST		2. SEX M		3. AGE 35	
4. DATE OF DEATH JAN 12 1917		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH TUBERCULOSIS		8. DISEASE OR INJURY TUBERCULOSIS		9. PERIOD OF ILLNESS 3 MONTHS	
10. SIGNATURE OF PHYSICIAN J. H. WEST		11. SIGNATURE OF WITNESSES J. H. WEST		12. SIGNATURE OF DECEASED WILLIAM WEST	
13. SIGNATURE OF REGISTRAR J. H. WEST		14. SIGNATURE OF CLERK J. H. WEST		15. SIGNATURE OF JURY J. H. WEST	
16. SIGNATURE OF JURY J. H. WEST		17. SIGNATURE OF JURY J. H. WEST		18. SIGNATURE OF JURY J. H. WEST	
19. SIGNATURE OF JURY J. H. WEST		20. SIGNATURE OF JURY J. H. WEST		21. SIGNATURE OF JURY J. H. WEST	
22. SIGNATURE OF JURY J. H. WEST		23. SIGNATURE OF JURY J. H. WEST		24. SIGNATURE OF JURY J. H. WEST	
25. SIGNATURE OF JURY J. H. WEST		26. SIGNATURE OF JURY J. H. WEST		27. SIGNATURE OF JURY J. H. WEST	
28. SIGNATURE OF JURY J. H. WEST		29. SIGNATURE OF JURY J. H. WEST		30. SIGNATURE OF JURY J. H. WEST	
31. SIGNATURE OF JURY J. H. WEST		32. SIGNATURE OF JURY J. H. WEST		33. SIGNATURE OF JURY J. H. WEST	
34. SIGNATURE OF JURY J. H. WEST		35. SIGNATURE OF JURY J. H. WEST		36. SIGNATURE OF JURY J. H. WEST	
37. SIGNATURE OF JURY J. H. WEST		38. SIGNATURE OF JURY J. H. WEST		39. SIGNATURE OF JURY J. H. WEST	
40. SIGNATURE OF JURY J. H. WEST		41. SIGNATURE OF JURY J. H. WEST		42. SIGNATURE OF JURY J. H. WEST	
43. SIGNATURE OF JURY J. H. WEST		44. SIGNATURE OF JURY J. H. WEST		45. SIGNATURE OF JURY J. H. WEST	
46. SIGNATURE OF JURY J. H. WEST		47. SIGNATURE OF JURY J. H. WEST		48. SIGNATURE OF JURY J. H. WEST	
49. SIGNATURE OF JURY J. H. WEST		50. SIGNATURE OF JURY J. H. WEST		51. SIGNATURE OF JURY J. H. WEST	
52. SIGNATURE OF JURY J. H. WEST		53. SIGNATURE OF JURY J. H. WEST		54. SIGNATURE OF JURY J. H. WEST	
55. SIGNATURE OF JURY J. H. WEST		56. SIGNATURE OF JURY J. H. WEST		57. SIGNATURE OF JURY J. H. WEST	
58. SIGNATURE OF JURY J. H. WEST		59. SIGNATURE OF JURY J. H. WEST		60. SIGNATURE OF JURY J. H. WEST	
61. SIGNATURE OF JURY J. H. WEST		62. SIGNATURE OF JURY J. H. WEST		63. SIGNATURE OF JURY J. H. WEST	
64. SIGNATURE OF JURY J. H. WEST		65. SIGNATURE OF JURY J. H. WEST		66. SIGNATURE OF JURY J. H. WEST	
67. SIGNATURE OF JURY J. H. WEST		68. SIGNATURE OF JURY J. H. WEST		69. SIGNATURE OF JURY J. H. WEST	
70. SIGNATURE OF JURY J. H. WEST		71. SIGNATURE OF JURY J. H. WEST		72. SIGNATURE OF JURY J. H. WEST	
73. SIGNATURE OF JURY J. H. WEST		74. SIGNATURE OF JURY J. H. WEST		75. SIGNATURE OF JURY J. H. WEST	
76. SIGNATURE OF JURY J. H. WEST		77. SIGNATURE OF JURY J. H. WEST		78. SIGNATURE OF JURY J. H. WEST	
79. SIGNATURE OF JURY J. H. WEST		80. SIGNATURE OF JURY J. H. WEST		81. SIGNATURE OF JURY J. H. WEST	
82. SIGNATURE OF JURY J. H. WEST		83. SIGNATURE OF JURY J. H. WEST		84. SIGNATURE OF JURY J. H. WEST	
85. SIGNATURE OF JURY J. H. WEST		86. SIGNATURE OF JURY J. H. WEST		87. SIGNATURE OF JURY J. H. WEST	
88. SIGNATURE OF JURY J. H. WEST		89. SIGNATURE OF JURY J. H. WEST		90. SIGNATURE OF JURY J. H. WEST	
91. SIGNATURE OF JURY J. H. WEST		92. SIGNATURE OF JURY J. H. WEST		93. SIGNATURE OF JURY J. H. WEST	
94. SIGNATURE OF JURY J. H. WEST		95. SIGNATURE OF JURY J. H. WEST		96. SIGNATURE OF JURY J. H. WEST	
97. SIGNATURE OF JURY J. H. WEST		98. SIGNATURE OF JURY J. H. WEST		99. SIGNATURE OF JURY J. H. WEST	
100. SIGNATURE OF JURY J. H. WEST		101. SIGNATURE OF JURY J. H. WEST		102. SIGNATURE OF JURY J. H. WEST	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10075

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10068

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Hampstead Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ARTHUR</u> First <u>- R -</u> Middle <u>WALSH</u> Last		4. DATE OF DEATH <u>Sept 28</u> Month <u>1958</u> Day <u>1958</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 3-1957</u>
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur R Walsh Sr</u>		14. MOTHER'S MAIDEN NAME <u>Susie R Rill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Arthur R Walsh - Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus Respiratory Infection</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Palsy-Quadroplegic.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shiloh</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Lipton, Hampstead Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Oct 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED'S NAME LAST FIRST MIDDLE _____		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
AGE YEARS MONTHS DAYS _____		DATE OF BIRTH MONTH DAY YEAR _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		PHYSICIAN'S NAME _____	
TIME OF DEATH _____		SIGNATURE OF EXAMINER _____	
DATE OF EXAMINATION _____		OFFICIAL USE _____	



RECEIVED IN THE OFFICE OF THE REGISTER OF DEATHS
BALTIMORE, MARYLAND
JAN 10 1900

10076

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN Ib 2 mos. 21 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			d. STREET ADDRESS 1524 Red Oak Drive		
3. NAME OF DECEASED (Type or print) First Edward Middle Randolph Last Walton			4. DATE OF DEATH Month September Day 10 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 6, 1866		9. AGE (In years last birthday) 92 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (retired)		10b. KIND OF BUSINESS OR INDUSTRY - Construction	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Roland Walton			14. MOTHER'S MAIDEN NAME Unknown Marshall		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None -	17. INFORMANT Springfield Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease.					INTERVAL BETWEEN ONSET AND DEATH Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from June 19, 1958 to September 10, 1958 , that I last saw the deceased alive on September 9, 1958 , and that death occurred at 8:43A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/10/58					
ACTUAL SIGNATURE Agustin del Campo		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/13/58	22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Juska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 15 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Huns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10077

10070

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS RFD Monrovia		
3. NAME OF DECEASED (Type or print) First Otis Middle L. Last Watkins		4. DATE OF DEATH Month Sept. Day 15 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1894	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Browningsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Maurice Watkins		14. MOTHER'S MAIDEN NAME Martha R. King		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-09-2561		
17. INFORMANT Mrs Byrd E. Watkins, Monrovia, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis, 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease, DUE TO (c) arteriosclerosis generaliz-				INTERVAL BETWEEN ONSET AND DEATH 1957 to 15 Sept 58
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 15 Sept, 1958 , to 15 Sept, 1958 , that I last saw the deceased alive on 15 Sept, 1958 , and that death occurred 7:10 P M, from the causes and on the date stated above.				
ACTUAL SIGNATURE Howard E. Hall		ADDRESS (Street, city or town, state) Apexville, Md		
PHYSICIAN'S NAME (Type) Howard E. Hall		DATE SIGNED 15 Sept 58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 17, 1958		
22c. NAME OF CEMETERY OR CREMATORY Bethesda Methodist		22d. LOCATION (City, town, or county) (State) Browningsville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Mohamuth		ADDRESS Damascus, Md.		
24a. REC'D BY REGISTRAR SEP 17 '58		24b. REGISTRAR'S SIGNATURE Charles S. Kline		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10071

Reg. Dist. No.

10078

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edinburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edinburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Sykesville P.O.</u>	
3. NAME OF DECEASED (Type or print) <u>MAMIE</u> First <u>EVQ</u> Middle <u>WILSON</u> Last		4. DATE OF DEATH <u>Sept.</u> Month <u>7</u> Day <u>1958</u> Year	
5. SEX <u>FF.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry B. Shidley</u>		14. MOTHER'S MAIDEN NAME <u>Susanna Biddinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss La Rue Wilson - Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, arteriosclerotic</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>heart disease, arteriosclerosis, gangrene</u> DUE TO (c) <u>lower extremities</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1955 to June 58</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>7 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7 June</u> , 19 <u>58</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-9-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Oakland</u>	22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 15 58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BROWN

WILLIAM BROWN

Name of Deceased		Date of Death	
WILLIAM BROWN		JAN 10 1900	
Age		Sex	
35		Male	
Race		Color	
White		White	
Place of Birth		Usual Residence	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
Cause of Death		Manner of Death	
DIPHTHERIA		Accident	
Period of Incubation		Time of Day	
10 Days		10:00 AM	
Place of Death		Name of Physician	
Home		J. B. BROWN	
Signature of Physician		Signature of Registrar	
J. B. BROWN		J. B. BROWN	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10079 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 12yrs. 2mos. 8days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Swanton RFD #2 11x-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Daniel Middle Floyd Last WILT			4. DATE OF DEATH Month September Day 16 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1908		9. AGE (In years last birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Adon C. Wilt			14. MOTHER'S MAIDEN NAME Luella Pritts		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary arteriosclerosis (c) Psychosis with syphilitic meningo-encephalitis. DUE TO cause last. 025X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with syphilitic meningo-encephalitis.					INTERVAL BETWEEN ONSET AND DEATH Minutes Years.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off bench, struck head against building.			
20c. TIME OF INJURY Month, Day, Year 9:05 a.m. 9/16/ 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/16/58	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/58		22c. NAME OF CEMETERY OR CREMATORY Phylor	
22d. LOCATION (City, town, or county) (State) Springfield Md.		23. FUNERAL DIRECTOR'S SIGNATURE Carl S. Hines		24a. REC'D BY REGISTRAR SEP 19 58	
24b. REGISTRAR'S SIGNATURE Carl S. Hines					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10080

CERTIFICATE OF DEATH

10073

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snydersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Snydersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>LYDIA A. Wise</u> First Middle Last		4. DATE OF DEATH Month <u>Sep</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep 24-1878</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Grose</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Sauble</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>40-03-6311</u>	
17. INFORMANT <u>Edw. J. Wise - Snydersburg Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic nephritis (arteriosclerosis)</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>1 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/14</u> 19 <u>58</u> , to <u>9/11</u> 19 <u>58</u> , that I last saw the deceased alive on <u>9/11</u> 19 <u>58</u> , and that death occurred at <u>6:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Foard</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md</u> DATE SIGNED <u>9/12/58</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Snydersburg</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. C. Sipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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10081

CERTIFICATE OF DEATH

10074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carröll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. Balti b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b llyrs, lmo, 2dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia Middle Seyfferth Last Wissner		4. DATE OF DEATH Month September Day 7 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 29, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10b. KIND OF BUSINESS OR INDUSTRY Cigar factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Otto Seyfferth		14. MOTHER'S MAIDEN NAME Helen Frederick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-09-3796	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1954 , to September 7, 1958 , that I last saw the deceased alive on September 7, 1958 , and that death occurred at 9:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Rita S. Glahn		DATE SIGNED 9/8/58	
PHYSICIAN'S NAME (Type) RITA S GLAHN		ADDRESS (Street, city or town, state) Springfield State Hosp. Sykesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-11-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Weer & Haight Funeral Home, Sykesville, Md.		ADDRESS	
24a. REC'D BY REGISTRAR SEP 9 '58		24b. REGISTRAR'S SIGNATURE Orlino S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10051

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>	
<p>2. Date of death: <u>10-15-1968</u></p>	
<p>3. Place of death: <u>At home</u></p>	
<p>4. Cause of death: <u>Heart disease</u></p>	
<p>5. Manner of death: <u>Natural</u></p>	
<p>6. Age at death: <u>65</u></p>	
<p>7. Sex: <u>Male</u></p>	
<p>8. Race: <u>White</u></p>	
<p>9. Marital status: <u>Married</u></p>	
<p>10. Occupation: <u>Engineer</u></p>	
<p>11. Education: <u>High School</u></p>	
<p>12. Date of birth: <u>10-15-1903</u></p>	
<p>13. Place of birth: <u>Massachusetts</u></p>	
<p>14. Date of death: <u>10-15-1968</u></p>	
<p>15. Place of death: <u>At home</u></p>	
<p>16. Cause of death: <u>Heart disease</u></p>	
<p>17. Manner of death: <u>Natural</u></p>	
<p>18. Age at death: <u>65</u></p>	
<p>19. Sex: <u>Male</u></p>	
<p>20. Race: <u>White</u></p>	
<p>21. Marital status: <u>Married</u></p>	
<p>22. Occupation: <u>Engineer</u></p>	
<p>23. Education: <u>High School</u></p>	
<p>24. Date of birth: <u>10-15-1903</u></p>	
<p>25. Place of birth: <u>Massachusetts</u></p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS